1

FOR STATE HEALTH DEPT.

Item 20 Film 240 8-4-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8052

018023
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
c. LENGTH OF STAY IN 1b: 6yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Rock Hall
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Herbert Middle Elbourn Last Batchelor
4. DATE OF DEATH: Month July Day 23 Year 1959

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-5-52
9. AGE (In years last birthday): 6 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Batchelor
14. MOTHER'S MAIDEN NAME: Helen Elbourn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mother — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Accidental Drowning
850 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
The child was playing in a row boat with companion. He reached overboard and fell into the water.

20c. TIME OF INJURY: Hour 12 p.m. Month, Day, Year 7/23 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Chesapeake Bay
20f. (City or town) Rock Hall (County) Kent (State) Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: William N. Saterma M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type):
DATE SIGNED: 7/23/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/25/59
22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel
22d. LOCATION (City, town, or county) Rock Hall (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L Lane
ADDRESS: Church Hill
24a. REC'D BY REGISTRAR DATE JUL 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kinna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
8M 2/57

Robert Farr
Chesterton

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8053 Reg. Dist. No. 18024

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Worton Rural
c. LENGTH OF STAY IN 1b: 23 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Worton Rural
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Margaret Middle — Last Besse

4. DATE OF DEATH: Month July Day 22 Year 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 30, 1879

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: MICHAEL Coughran

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Willis Wells, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 420.1 — Probable Coronary Thrombosis — Interval between onset and death: Short

DUE TO (b): Arterio sclerotic cardio vascular disease — several years

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of the Bladder - operation August 1958

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.: none

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Robert W. Farr M.D.

EXAMINER'S NAME (Type): Robert W. Farr, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 7/22/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 7-25-59

22c. NAME OF CEMETERY OR CREMATORY: STILL POND CEMTY

22d. LOCATION (City, town, or county) (State): STILL POND, MD

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy ADDRESS: STILL POND, MD.

24a. REC'D BY REGISTRAR DATE: JUL 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: Page 3 of certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8040 **CERTIFICATE OF DEATH** Reg. Dist. No. 08025

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Q. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown R.D. 1 17x-2
d. STREET ADDRESS: Chester Motel
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First EMORY Middle MILLER Last BONWILL
4. DATE OF DEATH: Month July Day 30 Year 59 19
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 251895
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10b. KIND OF BUSINESS OR INDUSTRY: Motel
11. BIRTHPLACE (State or foreign country): Kent Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Wm. H. Bonwill
14. MOTHER'S MAIDEN NAME: Florence May Miller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 218-14-0891
17. INFORMANT: Mrs. Adel B. Bonwill Address: Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Kidney failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days
916.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Extensive thermal burns — 7 days
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) With motor runing pt. filled tank from open gasoline can-fire and explosion.
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.: 1:30 p. m. July 23 1959
20d. INJURY OCCURRED While ☒ / Not while ☐ at work ☐ Farm
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State): Near Chestertown Q.A. Md.

21. I certify that I attended the deceased from 7-23, 19 59, to 7-30, 1959, that I last saw the deceased alive on 7-30, 19 59, and that death occurred at 5:45 p.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D. — ADDRESS (Street, city or town, state): Chestertown, Maryland — DATE SIGNED: 7-31-59

PHYSICIAN'S NAME (Type): A.C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 1 /59
22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Marvin V. Williams Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: AUG 5 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kimmey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8041 **CERTIFICATE OF DEATH** 08026

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Chestertown
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒X

3. NAME OF DECEASED (Type or print): First Thomas — Middle R. — Last Brockson

4. DATE OF DEATH: July 6 19 59

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒x DIVORCED ☐

8. DATE OF BIRTH: Oct. 10, 1888

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Brockson

14. MOTHER'S MAIDEN NAME: Minnie Mier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-30-0952A

17. INFORMANT: Thomas R. Brockson Jr. Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: very short

420.1

DUE TO (b): Coronary arterio sclerosis — 4 or 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) Chestertown (County) Kent, (State) Md.

21. I certify that I attended the deceased from 6/12, 19 59 to 7/6, 1959, that I last saw the deceased alive on 7/6, 19 59, and that death occurred at 10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D. ADDRESS (Street, city or town, state): Chestertown, Maryland DATE SIGNED

PHYSICIAN'S NAME (Type): Robert W. Farr, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 9, 1959

22c. NAME OF CEMETERY OR CREMATORY: Georgetown Cemetery

22d. LOCATION (City, town, or county): Georgetown, Kent Co. (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward E. Clows ADDRESS: Millington Md

24a. REC'D BY REGISTRAR DATE JUL 9 '59

24b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed ... 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8054 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Reg. Dist. No. 18027

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Coleman's Corner
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): at Home (RFD Worton)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Coleman's Corner nr. Worton, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Alonza — Middle: — Last: Brooks

4. DATE OF DEATH: Month: July — Day: 19 — Year: 1959

5. SEX: male

6. COLOR OR RACE: colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒X DIVORCED ☐

8. DATE OF BIRTH: Mar. 20, 1908

9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: various

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alexander Brooks

14. MOTHER'S MAIDEN NAME: Alice Piner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-12-3759

17. INFORMANT: Address: ertrude Brooks - Worton, Md. RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probably Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: short
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
Deceased suffered from heart trouble for some time. He was last seen by a physician 3 or 4 months ago. In a state of health not significantly different from the usual, last night, he was found dead in bed at about 8:30 A.M. today.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐XX

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour: a. m. p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒X, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒X Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: R. W. Farr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒X
DATE SIGNED: 7/19/59

EXAMINER'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July22, 1959
22c. NAME OF CEMETERY OR CREMATORY: Coleman's Cem.
22d. LOCATION (City, town, or county) (State): near - Worton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: JUL 21 '59
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8055 **CERTIFICATE OF DEATH** Reg. Dist. No. 08028

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle [illegible] Last BROOKS
4. DATE OF DEATH: Month July Day 9, Year 1959

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: February25,1881
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Labor
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Millington, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Brooks
14. MOTHER'S MAIDEN NAME: Martha Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-16-5432
17. INFORMANT: Paul Duckery, Address: Millington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 11 days.
DUE TO (b): Arteriosclerosis — years
DUE TO (c): Pyelonephritis — 3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 29, 19 59 to July 9, 19 59, that I last saw the deceased alive on July 8, 19 59, and that death occurred at 6 A M, from the causes and on the date stated above

ACTUAL SIGNATURE: Geza Koralewski M.D. ADDRESS (Street, city or town, state): MILLINGTON, MD DATE SIGNED: 7.9.59
PHYSICIAN'S NAME (Type): GEZA KORALEWSKI

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 12,1959
22c. NAME OF CEMETERY OR CREMATORY: Millington Colored Cemetery
22d. LOCATION (City, town, or county) (State): Millington, Kent Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows ADDRESS: Millington, Md.
24a. REC'D BY REGISTRAR DATE JUL 14 '59
24b. REGISTRAR'S SIGNATURE: Collins E Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8056 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Reg. Dist. No. 08029

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Betterton
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Chesapeake Hotel

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore CITY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 1419 N. Patterson Pk. Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruth — Middle: Frances — Last: Curran
4. DATE OF DEATH: Month: July — Day: 7 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 3, 1892
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleswoman
10b. KIND OF BUSINESS OR INDUSTRY: Hutzler's Store
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: James M. O'Neill
14. MOTHER'S MAIDEN NAME: ELEANOR RUTH

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, may be unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-20-8915
17. INFORMANT — Address: Eleanore Lomp 907 Locustvale Rd. Balto.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): probable heart attack occurring while swimming — INTERVAL BETWEEN ONSET AND DEATH: unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): prior heart disease, type unknown
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): probable heart attack occurred in Chesapeake Bay, while swimming

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): no gross evidence of injury. artificial resp. for 1 hr.
20c. TIME OF INJURY: Hour: 8 a.m. p.m. — Month, Day, Year: July 7 1959
20d. INJURY OCCURRED: White at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Chesapeake Bay
20f. (City or town): Betterton — (County): Kent — (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ at 9:00 p.m. July 7, 1959

ACTUAL SIGNATURE: Florence Deringer Joyce M.D.
EXAMINER'S NAME (Type): Florence Deringer Joyce
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: JULY 8, 1959

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/11/59
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John A. Moran — ADDRESS: 3000 E. Baltimore Street
24a. REC'D BY REGISTRAR — DATE: JUL 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Krank

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8042

CERTIFICATE OF DEATH

Reg. Dist. No. 18030

1. PLACE OF DEATH
a. COUNTY Kent
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Co. Hosp

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Millington
d. STREET ADDRESS --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Remby

4. DATE OF DEATH Month July Day 11, Year 1959

5. SEX female

6. COLOR OR RACE Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 7/11/59

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months 0d; Days
IF UNDER 24 HRS.: Hours 2; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Chestertown, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Raymond Remby

14. MOTHER'S MAIDEN NAME Anne Hutchins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO no

17. INFORMANT Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Prematurity
DUE TO
776X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/11/59, 19__, to 7/11/59, 19__, that I last saw the deceased alive on 7/11/59, 19__, and that death occurred at 3:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Willie M. Gatewood M.D.
ADDRESS (Street, city or town, state) Chestertown, Md.
DATE SIGNED 7/11/59

PHYSICIAN'S NAME (Type) William M. Gatewood

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7/12/59
22c. NAME OF CEMETERY OR CREMATORY Janes Cem.
22d. LOCATION (City town or county) (State) Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walker
ADDRESS Chestertown, Md.

24a. REC'D BY REGISTRAR DATE JUL 15 '59
24b. REGISTRAR'S SIGNATURE Carlina S. Kines

72286XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film #246 8-17-59 et

Kent 8057 **CERTIFICATE OF DEATH** Reg. Dist. No. 08031

1. PLACE OF DEATH
a. COUNTY Kent MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ----

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall
d. STREET ADDRESS ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Otto Middle Fredo Last Gossner
4. DATE OF DEATH Month July Day 26 Year 19 59

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑
8. DATE OF BIRTH July 11, 1893
9. AGE (In years last birthday) 66 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life...even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) New Jersey
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Gossner
14. MOTHER'S MAIDEN NAME Lizzie Will

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 159-03-8933
17. INFORMANT Mrs. Julia Gross Address Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b) Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Arterio Sclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 1, 19 59, to July 26, 19 59, that I last saw the deceased alive on July 26, 19 59, and that death occurred at 6:35 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Norbert C. Nitsch M.D. ADDRESS (Street, city or town, state) Rock Hall Md. DATE SIGNED

PHYSICIAN'S NAME (Type) NORBERT C. NITSCH

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF July 30-59
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel
22d. LOCATION (City, town, or county) Rock Hall (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane ADDRESS Church Hill
24a. REC'D BY REGISTRAR DATE AUG 3 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A III (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8043 **CERTIFICATE OF DEATH** Reg. Dist. No. 08032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M C I

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown, MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent + Queen Annes Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chestertown, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) — First: Baby Middle: Boy Last: Goldsboro

4. DATE OF DEATH — Month: July Day: 8 Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/6/59

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months / Days: 2 — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Albert Goldsboro

14. MOTHER'S MAIDEN NAME: Alice Elizabeth Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mother — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Foetal atelectasis
762.5
DUE TO (b): prematurity, (1lb 14oz)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-6, 1959 to 7-8, 1959, that I last saw the deceased alive on 7-8, 1958, and that death occurred at 1:10 PM, from the causes and on the date stated above

ACTUAL SIGNATURE: Harry Paul Ross M.D.
ADDRESS (Street, city or town, state): 203 N Queen St, Chestertown, Md
DATE SIGNED:
PHYSICIAN'S NAME (Type): Harry Paul Ross

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 9, 1959

22c. NAME OF CEMETERY OR CREMATORY: Broad Neck

22d. LOCATION (City, town or county) (State): near Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Kenneth Walker
ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE JUL 10 '59

24b. REGISTRAR'S SIGNATURE: Colbert S. Knott

VS A15 (4)
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8044

CERTIFICATE OF DEATH

Reg. Dist. No. 08033

1. PLACE OF DEATH a. COUNTY: Kent — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 5 years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent Street
d. STREET ADDRESS: Kent Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: Agnes Last: Gorsuch
4. DATE OF DEATH: Month: July Day: 17 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 20, 1891
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Ritmiller
14. MOTHER'S MAIDEN NAME: Agusta Cooney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 215-20-1190
17. INFORMANT: Charles W. Gorsuch, Address: Chestertown, Md. (son)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Cerebral hemorrhage	2 hours ?
331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (b)	Hypertension	7 years
DUE TO (c)	Arteriosclerosis	7 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-31- 19 57, to 7-17 19 59, that I last saw the deceased alive on 7-1 19 59 and that death occurred at 3:00 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D. ADDRESS (Street, city or town, state): Chestertown, Maryland DATE SIGNED: 7-17-59

PHYSICIAN'S NAME (Type): A.C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/19/59
22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.
22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: JUL 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHY AN: The law requires that the death certificate be executed wi
may be retained by the hospitol or nding physician.

TO FUNERAL [illegible]ECTOR: After this certificate has been signed by the attending physician and complete · death. Page 4
page 3 shou[illegible]e detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. funeral director, ould be filed with

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8058

CERTIFICATE OF DEATH

Reg. Dist. No. 08034

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a STATE: Maryland b COUNTY: Kent

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Chestertown

c. LENGTH OF STAY IN 1b: life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: near Fairlee

d STREET ADDRESS: RFD * Fairlee

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First Albert Middle B. Last Groves

4. DATE OF DEATH: Month July Day 25, Year 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 1, 1886

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Tenant

11. BIRTHPLACE (State or foreign country): Kent Co. Maryland

12 CITIZEN OF WHAT COUNTRY?: Usa

13. FATHER'S NAME: James H. Groves

14. MOTHER'S MAIDEN NAME: Sarah Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-38-1107

17. INFORMANT: Address: Mrs. Albert B. Groves - Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Cardio Vascular

DUE TO

(c) Asteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1 1959, to July 25 1959, that I last saw the deceased alive on July 25 1959, and that death occurred at 2:40 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Norbert C. Nitsch M.D. ADDRESS (Street, city or town, state): Rock Hall Md DATE SIGNED: 7/25/59

PHYSICIAN'S NAME (Type): Norbert C. Nitsch Rock Hall, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 28, 1959

22c. NAME OF CEMETERY OR CREMATORY: St. Paul Cem.

22d. LOCATION (City, town, or county) (State): near Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Wilbur Wells ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: JUL 28 '59

24b. REGISTRAR'S SIGNATURE: Calvin L. Evans

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8045 . **CERTIFICATE OF DEATH**

Reg. Dist. No. 18035

1. PLACE OF DEATH — a. COUNTY: Queen — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dent Memorial Queen Anne Co. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crumpton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Susan — Middle: Maria — Last: Hudson

4. DATE OF DEATH: Month: 7 — Day: 12 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/25/1883

9. AGE (In years Last Birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Wallis

14. MOTHER'S MAIDEN NAME: Hattie Godwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Address: Brighton Crumpton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Decompensation

DUE TO (b): Acute Pulmonary Congestion Bronchial Pneumonia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18):

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 7/4, 1959 to 7/12, 1959, that I last saw the deceased alive on 7/11, 1959, and that death occurred at 9:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William Gatewood M.D. ADDRESS (Street, city or town, state): Centerville, Md. DATE SIGNED: 7/13/59

NAME (Type): WILLIAM GATEWOOD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 7/14/59 — 22c. NAME OF CEMETERY OR CREMATORY: Crumpton — 22d. LOCATION (City, town, or county) (State): Green Anvil's Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lance — ADDRESS: Church Hill

24a. REC'D BY REGISTRAR — DATE: JUL 20 '59 — 24b. REGISTRAR'S SIGNATURE: Esther S. Kemp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8046 **CERTIFICATE OF DEATH** Reg. Dist. No. 06036

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: KENT & QUEEN ANNE'S

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
d. STREET ADDRESS: 415 CALVERT ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARY — Middle: ETHEL — Last: JOHNSON

4. DATE OF DEATH: Month: JUL. — Day: 11 — Year: 1959

5. SEX: F

6. COLOR OR RACE: COL

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/25/1881

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14 MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: HOSPITAL CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: INTESTINAL OBSTRUCTION — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m. / p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JUL 11, 19 59 to JUL 11, 19 59 that I last saw the deceased alive on JUL 11, 19 59, and that death occurred at 5 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A. T. Keefe M.D. — ADDRESS (Street, city or town, state): CHESTERTOWN, Md — DATE SIGNED: 7.11.59

PHYSICIAN'S NAME (Type): A.T. KEEFE M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b DATE THEREOF: 7/15/59 — 22c. NAME OF CEMETERY OR CREMATORY: Georgetown Cem. — 22d. LOCATION (City, town, or county) (State): near Chestertown, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Kenneth Waller — ADDRESS: Chestertown Md.

24a. REC'D BY REGISTRAR DATE: JUL 15 '59 — 24b REGISTRAR'S SIGNATURE: Esther S. Turner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and sample fully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be forwarded with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8059 **CERTIFICATE OF DEATH** Reg. Dist. No. 118037

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lynch
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Lynch, Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Lynch
d. STREET ADDRESS: Lynch
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Howard Middle Edward Last Mench
4. DATE OF DEATH: Month July Day 14 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 11, 1889
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mason
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (State or foreign country): Kent Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Edward Mench
14. MOTHER'S MAIDEN NAME: Katie Linda Geiser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 207 10 1538
17. INFORMANT: Mrs. Howard E Mench Address: Lynch, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO (b): Arteriosclerosis generalized — 6 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): ____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 4, 1954, to July 14, 1959, that I last saw the deceased alive on July 14, 1959, and that death occurred at 2:05 p. M, from the causes and an the date stated abave.

ACTUAL SIGNATURE: A C Dick M.D. ADDRESS (Street, city or town, state): Chestertown, Md. DATE SIGNED: 7-14-59

PHYSICIAN'S NAME (Type): A. C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7-17-59
22c. NAME OF CEMETERY OR CREMATORY: STILL POND CEMTY
22d. LOCATION (City, town, or county) (State): STILL POND, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy ADDRESS: STILL POND, MD.
24a. REC'D BY REGISTRAR DATE: JUL 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8060 **CERTIFICATE OF DEATH** Reg. Dist. No. 08038

1. PLACE OF DEATH
a. COUNTY Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rock Hall

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First John Middle Lost Nadolny

4. DATE OF DEATH Month July Day 17 Year 1959

5. SEX M

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH June 4, 1904

9. AGE (In years last birthday) 55 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Ashley Packing Co.

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wojciech Nadolny

14. MOTHER'S MAIDEN NAME Mary Borjas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-07-1101

17. INFORMANT Address Stanislaus Nadolny 614 South Washington Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

420..

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Hypertensive Cardiovascular

DUE TO (c) Aortic Stenosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 16, 19 59 to July 17, 19 59 that I last saw the deceased alive on July 17, 19 59, and that death occurred at 1:00 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D. ADDRESS (Street, city or town, state) Rock Hall DATE SIGNED 7/17/59

PHYSICIAN'S NAME (Type) [illegible] Rock Hall, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF July 21, 1959

22c. NAME OF CEMETERY OR CREMATORY St. St[illegible]ng

22d. LOCATION (City, town, or county) (State) Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber ADDRESS 705 S. Ann St; Balto.

24a. REC'D BY REGISTRAR DATE JUL 20 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8047 **CERTIFICATE OF DEATH**

Reg. Dist. No. 08039

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Kent & Queen Annes

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 229 Kent Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: E — Last: Nicholson

4. DATE OF DEATH: Month: July — Day: 5 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: January 30, 1884

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Robert G. Nicholson

14. MOTHER'S MAIDEN NAME: Laura Lusby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Hospital Records, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Bed Benfinement — 12 days

DUE TO (c): Spontaneous subarachmoid hemorrhage — 12 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from June 24, 1959, to July 5, 1959, that I last saw the deceased alive on July 5, 1959, and that death occurred at 8:00 AM, from the causes and on the date stated above

ACTUAL SIGNATURE: R L T W Farr M.D.

ADDRESS (Street, city or town, state): Chestertown, Md.

DATE SIGNED: 7/5/59

PHYSICIAN'S NAME (Type): Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 7, 1959

22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.

22d. LOCATION (City, town or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells

ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: JUL 7 '59

24b. REGISTRAR'S SIGNATURE: Emma L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8061 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 Fumg 2+6 7-31-59 et

08040 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Corton Creek Marina
c. LENGTH OF STAY IN 1b: short
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA * Kent & Queen Anne Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Pennsylvania — COUNTY: York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): York RFD
d. STREET ADDRESS: Rfd # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Virginia Middle Carolyn Last Peterson

4. DATE OF DEATH: Month July Day 25 Year 1959

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 15, 1958
9. AGE (If years last birthday): 1 yrs.
IF UNDER 1 YEAR: Months 1 Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Penna
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Peterson
14. MOTHER'S MAIDEN NAME: Alice Uzle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Max Anstine Address: York, Penna

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASPHIXIATION — INTERVAL BETWEEN ONSET AND DEATH: 20 min.
DUE TO
(b): DROWNING
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): FELL OFF A BOAT.
20c. TIME OF INJURY: Hour 6 p. m. Month, Day, Year JUL 25 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): BOAT
20f. (City or town) WORTON (County) KENT (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: A. T. Keefe M.D.
EXAMINER'S NAME (Type): Arthur T. Keefe
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 7.26.59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 28, 1959
22c. NAME OF CEMETERY OR CREMATORY: Mt. Rose Cem.
22d LOCATION (City, town, or county) (State): York Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: J Willis Wells
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE JUL 28 '59
24b. REGISTRAR'S SIGNATURE: Charles L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8048 **CERTIFICATE OF DEATH** 08041

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT & QUEEN ANNE'S HOSP

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENNEDYVILLE
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First TERRY Middle LEE Last REESE

4. DATE OF DEATH: Month JULY Day 14 Year 1959

5. SEX: F

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 12, 1959

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months — Days 2 — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES BURTON REESE

14. MOTHER'S MAIDEN NAME: MARGARET ELIZABETH MONEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: HOSPITAL RECORDS Address: CHESTERTOWN, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus + severe + intractable

DUE TO

(b) spinal bifida —

DUE TO

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 days in

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/12, 19 59, to 7-14, 19 59, that I last saw the deceased alive on 7-14, 19 59, and that death occurred at 12 00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Farr M.D. ADDRESS (Street, city or town, state): Chestertown, Md DATE SIGNED: 7/14/59

PHYSICIAN'S NAME (Type): ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 7-16-59

22c. NAME OF CEMETERY OR CREMATORY: CHESTER CEMETERY

22d. LOCATION (City, town or county) (State): CHESTERTOWN, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Victor M. Kennedy ADDRESS: STILL POND, MD

24a. REC'D BY REGISTRAR DATE: JUL 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. Thomas

7-16-1959

1

8062

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

118042

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CORNELIA Middle Last RODNEY

4. DATE OF DEATH: Month JULY Day 16 Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 13 1889

9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM CRAIGHTON

14. MOTHER'S MAIDEN NAME: ANNIE COLEMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Address: Mr Thomas C. Rodney Oak Lea Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema
DUE TO (b): Cardiac Calcosis, Hypertension
DUE TO (c): Diabetes Mellitus of 5 yrs duration

INTERVAL BETWEEN ONSET AND DEATH

443 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Tuesday, 19 59, to July 16, 19 59, that I last saw the deceased alive on July 16, 19 59, and that death occurred at 9 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert Nitsch M.D. ADDRESS (Street, city or town, state): Rock Hall DATE SIGNED: 7/17/59

PHYSICIAN'S NAME (Type): NORBERT NITSCH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: JULY 19

22c. NAME OF CEMETERY OR CREMATORY: WESLEY CHAPEL

22d. LOCATION (City, town, or county) (State): ROCK HALL MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Land ADDRESS: Church Hill Md

24a. REC'D BY REGISTRAR DATE: JUL 23 '59

24b. REGISTRAR'S SIGNATURE: Clinton L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8049

CERTIFICATE OF DEATH

Reg. Dist. No. 08043

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: entire life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: EMERG Room Kent & Queen Anne's

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kennedyville
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle ANN Last ROY

4. DATE OF DEATH: Month July Day 19 Year 1959

5. SEX: Female

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 28, 1958

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 6 Days 21 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRED (N) ROY

14. MOTHER'S MAIDEN NAME: MARY MARJORIE WILSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: FRED ROY Address: Kennedyville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): OVERWHELMING INFECTION - WITH
Dehydration DUE TO VOMITING & DIARRHEA —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) DUE TO HAD been seen by ANOTHER M.D. Jul 16,
(c) 17 & 18 —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 19 July, 1959, to 19 July, 1959, that I last saw the deceased alive on Never, 19, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harry Paul Ross M.D. ADDRESS (Street, city or town, state): 223 N. Queen St. DATE SIGNED: 7/19/59

PHYSICIAN'S NAME (Type): HARRY PAUL ROSS Chestertown Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL 22b. DATE THEREOF: 7-21-59 22c. NAME OF CEMETERY OR CREMATORY: MT. ZION CEMTY 22d. LOCATION (City, town, or county) (State): STILL POND MD

23. FUNERAL DIRECTOR'S SIGNATURE: Victor M. Kennedy ADDRESS: STILL POND MD

24a. REC'D BY REGISTRAR DATE: JUL 21 '59 24b. REGISTRAR'S SIGNATURE: Arthur S. Krems

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8050 **CERTIFICATE OF DEATH** Reg. Dist. No. 08044

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rock Hall
d. STREET ADDRESS: Sharp St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANN Middle Last SHIRK

4. DATE OF DEATH: Month July Day 29 Year 1959

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 15 1885

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeping

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Middletown Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Franklin Ober

14. MOTHER'S MAIDEN NAME: Emma Nissley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 203-07-0654A

17. INFORMANT: Mr. P. O. Shirk Address: Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Generalized Arteriosclerosis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 19 55 to July 30 19 59 that I last saw the deceased alive on July 29 19 59 and that death occurred at 5:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Willis M. Tatum M.D.

ADDRESS (Street, city or town, state):

DATE SIGNED: 7/30/59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 1 1959

22c. NAME OF CEMETERY OR CREMATORY: Mt. Tunnel Cemetery

22d. LOCATION (City, town, or county) (State): Elizabethtown Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Marvin V. Williams Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: JUL 31 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8051

CERTIFICATE OF DEATH

Reg. Dist. No. 08045

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 45 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne's Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Tucker

4. DATE OF DEATH: Month: 7 — Day: 25 — Year: 19 59

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-25-59

9. AGE (In years last birthday): N.B. yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Franklin Burgess Tucker

14. MOTHER'S MAIDEN NAME: Betty Kimball

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mother — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Inmaturity
776x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/25/59 19___, to 7/25/59 19___, that I last saw the deceased alive on 7/25/59 19___, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William M. Patterson M.D. — ADDRESS (Street, city or town, state): Rock Hall — DATE SIGNED: 7/25/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 7/25/59 — 22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel — 22d. LOCATION (City, town, or county) (State): Rock Hall Md

23. FUNERAL DIRECTOR'S SIGNATURE: Elgin L Lam — ADDRESS: Church Hill

24a. REC'D BY REGISTRAR DATE: JUL 30 '59

24b. REGISTRAR'S SIGNATURE: Clifton B. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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